SETTLEMENT AGREEMENT
The Department of Managed Health Care
and
PacifiCare of California

PREAMBLE

As specifically described below, this Settlement Agreement recognizes Plan's voluntary decision to establish a process to give individuals whose IFP HMO (defined below) coverage was canceled the option of purchasing prospective IFP HMO coverage without medical underwriting and to reimburse past out-of-pocket medical expenses of specific individuals. The Department acknowledges that the Plan did not rescind coverage during the relevant periods and instead prospectively canceled IFP HMO coverage of specific enrollees. This Settlement Agreement also provides individuals with a choice of dispute resolution processes designed to expedite the resolution of any potential claims, including claims for past out-of-pocket medical expenses. Except as otherwise expressly set forth herein, nothing in this Settlement Agreement limits an individual's right to pursue any available legal remedies.

I. FACTUAL BACKGROUND

PacifiCare of California ("Plan") is a licensed health care service plan, license No. 933-0126. The California Department of Managed Health Care ("Department") enforces the laws that govern health care service plans in California.

Between January 2004 and present, approximately 13,721 subscribers were enrolled in Plan's health plan known as PacifiCare of California Individual and Family Plan HMO ("IFP HMO"). During this period of time the Plan canceled the IFP HMO membership agreements of 64 enrollees.

Section 1389.3 of the Health and Safety Code prohibits a health care service plan from engaging in the practice of post claims underwriting, which means "the rescinding, canceling, or limiting of an enrollee's contract due to the plan's failure to complete medical underwriting and to resolve all reasonable questions prior to issuing the plan contract." (Health & Safety Code

§ 1389.3.) Section 1389.3 further provides that "[t]his section shall not limit a plan's remedies upon a showing of willful misrepresentation."

The Department and the Plan execute this Settlement Agreement, which shall be final and binding on both of them subject to the terms and conditions set forth herein.

II. UNDERSTANDINGS AND AGREEMENTS

The parties agree as follows:

A. **Rescissions**. Plan reserves its rights to cancel or rescind IFP HMO membership agreements of enrollees who enroll after June 11, 2008, in accordance with California law. For any persons issued IFP HMO membership agreements prior to June 11, 2008, Plan agrees to concurrently offer arbitration under Option 3 for such persons whose IFP HMO membership agreements are canceled or rescinded based on information provided in connection with applications for such membership agreements.

B. **Notice**. "FORMER ENROLLEES" means individuals whose IFP HMO membership agreements were canceled between January 1, 2004, and June 11, 2008 based on the claim that such individuals provided inaccurate information in connection with applications for such membership agreements, and who have not already addressed their disputes about such cancellation pursuant to a judicial judgment, arbitration award or decision, prior reinstatement, prior Department Order or Letter of Agreement, settlement, or settlement agreement. Within 45 days following the effective date of this Settlement Agreement, Plan will commence reasonable efforts to contact FORMER ENROLLEES. If necessary, such reasonable efforts shall include use of an independent search service to assist Plan in confirming the whereabouts of such FORMER ENROLLEES, and the use of such service shall satisfy the Plan's obligation under this paragraph to make reasonable efforts. The notification to FORMER ENROLLEES shall be made by overnight mail or private delivery service with confirmation of delivery to the most recently available address identified pursuant to Plan's reasonable search efforts. The purpose of this notification is to inform these FORMER ENROLLEES of Plan's voluntary offer. The voluntary offer to the FORMER ENROLLEES to sell them IFP HMO coverage (that is most comparable to their canceled IFP HMO policy) without medical underwriting shall be made in

writing and shall be open for a period of 90 days from the date of delivery to the most recently available address identified pursuant to Plan's reasonable search efforts. Enrollment and continued membership will be conditioned on meeting nonmedical underwriting eligibility requirements set forth in the applicable IFP HMO membership agreement. These non-medical underwriting eligibility requirements include, by way of example, residence in a service area, age limits for members and their dependents, signing an enrollment form, and paying all applicable premiums going forward and otherwise complying with the terms of the IFP HMO policy. The effective date of IFP HMO coverage will be the first day of the month following Plan's receipt of the FORMER ENROLLEE'S first month premium. Plan's voluntary offer to sell IFP HMO coverage to these FORMER ENROLLEES without medical underwriting is not and shall not be construed as an admission of noncompliance or liability or as a waiver of rights or defenses, including any statute of limitation defenses. Once the Plan has made the reasonable efforts to contact the FORMER ENROLLEES to make the voluntary offers set forth in this Settlement Agreement, Plan's obligation to contact these FORMER ENROLLEES shall cease. However, Plan will accept independent or direct requests from FORMER ENROLLEES who were not contacted by the Plan despite the Plan's reasonable search efforts to accept Plan's voluntary offer to sell IFP HMO coverage without medical underwriting if received on or before December 31, 2008.

C. **Voluntary Offer.**

1. Plan will offer to permit FORMER ENROLLEES to purchase prospective IFP HMO coverage without medical underwriting ("voluntary offer").

2. Plan will not require FORMER ENROLLEES who are offered the right to purchase IFP HMO coverage without medical underwriting under this Settlement Agreement to execute a release of all claims against Plan as a condition of acceptance of this voluntary offer to sell prospective IFP HMO coverage. FORMER ENROLLEES who receive and/or accept the voluntary offer may pursue any legal remedies or claims available to them for causes of action they believe they have a right to assert against Plan. However, releases may be executed as part of the expedited dispute resolution options described in paragraph II.G. below.

D. **Unique Claims**. The parties recognize that FORMER ENROLLEES, including the SPECIFIED FORMER ENROLLEES described in paragraph II.F, below, may claim entitlement to damages in connection with Plan's cancellation actions, which claims are entirely personal and unique for every person and factually different from every other of the FORMER ENROLLEES or SPECIFIED FORMER ENROLLEES.

E. **Reservation of Rights**. Plan reserves the right to assert any and all claims and defenses against any FORMER ENROLLEE, including, without limitation, defenses to any claim or action brought by or on behalf of such FORMER ENROLLEE, whether in court, in binding arbitration, in another forum, or under the expedited dispute resolution options described in paragraph II.G. It is acknowledged and agreed that by making the offer to sell prospective IFP HMO coverage, that the Plans actions shall not be construed as an admission of noncompliance or liability or as a waiver of rights or defenses, including any statute of limitation defenses, nor shall it be construed to revive claims or causes of action. As more fully explained in paragraph II.G, it is further acknowledged and agreed that Plan has admitted no legal obligation to pay FORMER ENROLLEES for any medical expenses they may have incurred since the date of the Plan's previous cancellation of coverage described herein.

F. **Specified Former Enrollees**. In addition to Plan's voluntary offer of prospective IFP HMO coverage without medical underwriting to FORMER ENROLLEES, Plan will offer specifically identified FORMER ENROLLEES included in the confidential list attached to this Settlement Agreement as Confidential Attachment A ("SPECIFIED FORMER ENROLLEES"), the option to be reimbursed for paid (or legally obligated to pay) out-of-pocket medical expenses (hereafter the term "Paid Out-Of-Pocket Medical Expenses" shall have the meaning and be subject to the standards as set forth below in this paragraph II.F.) without any determination of the appropriateness of the prior cancellation as described below.

1. Plan will offer to sell the SPECIFIED FORMER ENROLLEES prospective IFP HMO coverage without medical underwriting, as described in paragraph II.B, above.

2. Further, Plan will undertake reasonable efforts, as described above in paragraph II.B, to contact the SPECIFIED FORMER ENROLLEES to make a written offer to provide a financial settlement to each individual. The financial settlement offer shall be an amount equal to the SPECIFIED FORMER ENROLLEE'S Paid Out-Of-Pocket Medical Expenses for medical services received during the Gap Period (which runs from the date the enrollees' coverage was canceled by the Plan through the date the offer letter is received at the address identified through the Plan's reasonable efforts pursuant to paragraph II.B. above). Such Paid Out-Of-Pocket Medical Expenses shall be subject to reasonable documentation requirements. Paid Out-Of-Pocket Medical Expenses shall not include any expenses covered or reimbursed by any third party payer, health care service plan, insurance company contract (including but not limited to any applicable disability, workers' compensation, group, individual or employer self-insurance coverage), or the proceeds of any judgment or settlement.

3. Such Paid Out-Of-Pocket Medical Expenses shall include only expenses for services that were medically necessary covered services within the parameters of the IFP HMO benefits structure contained in the canceled IFP HMO membership agreement in effect at the time the SPECIFIED FORMER ENROLLEE'S coverage was canceled.

4. This financial settlement offer will be contingent upon the SPECIFIED FORMER ENROLLEE'S binding written agreement that acceptance of the financial settlement will result in a full, final and complete general release and the resolution of any and all disputes between the Plan and the SPECIFIED FORMER ENROLLEE arising from or related to the Plan's cancellation of IFP HMO coverage including, but not limited to, any claims for additional damages (including pain and suffering, punitive damages, and all other damages) or injunctive relief.

5. If the SPECIFIED FORMER ENROLLEE disputes the Plan's determination of medical necessity, the scope of benefits coverage, or the amount of proposed reimbursement, the SPECIFIED FORMER ENROLLEE shall be immediately referred to the expedited dispute resolution processes described in Option 2 and Option 3

in paragraph II.F, except that the sole issue to be determined shall be the amount of reimbursement of Paid Out-Of-Pocket Medical Expenses during the Gap Period.

6. The election of this alternative dispute resolution remedy will be at the SPECIFIED FORMER ENROLLEE'S sole discretion. If a SPECIFIED FORMER ENROLLEE declines to accept this alternative dispute resolution remedy, he/she will be provided all the rights and remedies that this Settlement Agreement provides to all FORMER ENROLLEES and Plan will retain the right to assert any and all claims and defenses.

G. **Expedited Dispute Resolution Options.** The parties recognize that certain FORMER ENROLLEES may claim entitlement to damages in connection with the prior cancellations. As stated in paragraph II.C, this Settlement Agreement does not preclude such persons from pursuing legal recourse for causes of action they believe that they have a right to assert against Plan. Plan has agreed to make available the three options set forth below on an expedited basis in lieu of other legal remedies, to FORMER ENROLLEES whose claims have not otherwise been the subject of: an arbitration award or decision, court judgment, settlement, or release of liability. Plan reserves the right to assert any and all claims and defenses against any FORMER ENROLLEE, including, without limitation, defenses to any claim or action brought by or on behalf of such FORMER ENROLLEE, whether in court, in binding arbitration, in another forum, or under the expedited dispute resolution options described in this paragraph II.G. It is acknowledged and agreed that by making the offer of additional dispute resolution options, that the Plan's actions shall not be construed as an admission of noncompliance or liability or as a waiver of rights or defenses, including any statute of limitation defenses.

Option 1. Former Enrollees who desire to negotiate their claims directly with Plan: FORMER ENROLLEES may submit a written claim for damages to the Plan, supported by any invoices, canceled checks, and other supporting documentation that FORMER ENROLLEE may have available. The Plan may request authorization for the release of medical records and bills and copies of such medical records to support the claim. Within 60 days of receipt of such claim and any requested supporting medical

records, Plan will (a) provide a written offer of final settlement of all claims to the claimant, or (b) dispute the claim. The written offer of final settlement may be conditioned on the receipt of such additional supporting documentation as may be reasonably necessary to substantiate the claim and on the Plan's obtaining a general release of liability from the FORMER ENROLLEE in exchange for any such settlement. In the event that a final settlement of all claims is not achieved, the claimant shall retain his or her rights to pursue legal recourse against the Plan or to opt for Option 2 or Option 3 below.

Option 2. Former Enrollees whose claims are limited to Paid Out-Of-Pocket Medical Expenses for medical expenses received during the Gap Period that are less than or equal to $25,000: Such persons may opt to resolve all of their claims through an expedited proceeding that shall be conducted by a JAMS arbitrator on the basis of a written record without appearance by any party. The record shall consist of evidence of the claimant's Paid Out-Of-Pocket Medical Expenses during the Gap Period, evidence that such expenses were for medically necessary covered services within the parameters of the benefits structure contained in the claimant's canceled IFP HMO membership agreement and were not reimbursed by any third party, and the Plan's record of decision of the cancellation, provided that both parties shall have the right to submit additional written statements and materials to the arbitrator. No discovery shall be permitted, except that Plan may obtain claimants' medical records and bills for purposes of verifying claims, and FORMER ENROLLEES must execute written authorizations for the release of medical and other records as reasonably requested by the Plan. Plan will pay for the cost of the arbitrator. The available remedies for any arbitration award issued under this Option 2 shall be limited to documented Paid Out-Of-Pocket Medical Expenses during the Gap Period and shall resolve any and all claims, arising from or in connection with the Plan's cancellation of IFP HMO memberships agreements by FORMER ENROLLEES who choose this option.

Option 3. Former Enrollees whose claims for Paid Out-Of-Pocket Medical Expenses are greater than $25,000 or include claims for damages other than Paid Out-Of-Pocket Medical Expenses for medical services received during the Gap Period: Such persons may opt to resolve all of their claims through binding arbitration held in Sacramento, San Francisco, Los Angeles, or San Diego (whichever is more convenient to the claimant) before one arbitrator. The arbitration under this Option 3 shall be administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures, subject to the modifications set forth in this Agreement. The Plan will pay for the cost of the arbitrator.

The proceedings described in Option 2 and Option 3 immediately above shall be subject to the following additional requirements:

a. The arbitrator shall be selected randomly by JAMS from a group of no more than six arbitrators who are mutually agreed upon by the Department and Plan. Such arbitrators shall follow applicable California law, including the Knox-Keene Act and the recent appellate court decision in Hailey v. California Physicians' Service, 158 Cal.App.4th 452 (2007) (as may be modified by subsequent decisions) and shall periodically consult with each other to assure consistency in decision-making.

b. Arbitration decisions shall be final, subject to judicial enforcement in accordance with California Code of Civil Procedure Sections 1285 et seq., and shall resolve all claims and disputes between FORMER ENROLLEES and the Plan relating to the Plan's cancellation of IFP HMO membership agreements with such FORMER ENROLLEES. The proceedings (including, without limitation, statements, deliberations, decisions, and documents made, created or issued therein by the arbitrator, any party or any other person) are a compromise of claims and: (i) shall be inadmissible in any other legal or administrative proceeding, and (ii) shall not be used for any purpose in any legal or administrative proceeding, including (without limitation) for purposes of collateral estoppel or res judicata. However, notwithstanding the foregoing, the proceeding may be used to establish that a FORMER ENROLLEE submitted claims, whether those claims

were resolved, and whether the FORMER ENROLLEE released any claims. All documents (and copies thereof) exchanged shall be treated as confidential and returned to the producing parties promptly after conclusion of the arbitration. In the event that a settlement or award agreed to or issued is, under Option 3 above, based upon bills received by a FORMER ENROLLEE from a provider prior to June 11, 2008 that remain owed but were not paid by a FORMER ENROLLEE to a provider, Plan shall, at its sole discretion, have the right to directly resolve any such bills with the billing provider and deduct the amount paid to the billing provider from the amount of the settlement or award.

c. Arbitration shall further be conditioned on the execution by the FORMER ENROLLEE and the Plan of the attached written Arbitration Submission Agreements (appended hereto at Exhibit C) to be used for Option 2 or Option 3 above.

H. **Settlement.** By entering into this Settlement Agreement, the parties hereby settle all pending enforcement matters and all issues, accusations, and claims that the Department has or may have against the Plan, including, without limitation, any alleged violation of section 1389.3 of the Health and Safety Code or any other provision of the Knox-Keene Health Care Service Plan of 1975, relating to or arising from any cancellation of IFP HMO membership agreements that may have occurred on or before June 11, 2008. The Department's Final Report of the Non-Routine Medical Survey on Post-Claims Underwriting regarding the Plan's cancellation practices will not be referred to the Division of Enforcement for any further administrative action or otherwise referred for enforcement. The Final Report may report the existence of this Settlement Agreement.

I. **Administrative Fine**. The Department contends an administrative fine is warranted, but recognizes Plan's good faith efforts to improve medical underwriting and cancellation practices and to afford FORMER ENROLLEES a means of expedited dispute resolution. Plan contends that its actions regarding cancellation were in accordance with California law. Nevertheless, Plan agrees to pay an administrative fine of $50,000 within ten business days in order to resolve all matters with the Department as provided in this Settlement Agreement.

J. **Corrective Action**. On or before July 31, 2008, Plan will submit a corrective action proposal ("CAP") to address completion of medical underwriting, resolution of all reasonable questions arising from written information submitted on or with an application, and reasonable efforts to ensure the accuracy and completeness of the application before issuing IFP HMO coverage. At a minimum, Plan's corrective action plan will include the topics contained in Attachment B. The Department acknowledges that Plan has already commenced efforts on certain elements of the required CAP.

1. Within 120 calendar days of receipt of the Department's Final Report approving Plan's CAP, Plan will complete implementation of the CAP, provided that a reasonable additional time shall be permitted for implementation of essential systems (such as information technology) that typically require additional time or matters outside the Plan's control such as the approval of any documents submitted to the Department for approval. Plan and the Department may confer in good faith as necessary and agree to reasonable modifications of the CAP.

2. Pursuant to section 1380 of the Knox-Keene Act, the Department will conduct a follow up survey to verify that Plan has timely and substantially implemented its CAP. Upon completion of the follow up survey, if the Department determines that the Plan failed to substantially and timely implement its CAP, the Department may impose an administrative fine, proportional to the identified deficiencies, if any, of up to $500,000.

K. **No Admission**. The Department agrees that Plan's voluntary offer, and this Settlement Agreement, are not made pursuant to any order, consent agreement, stipulated judgment, or any other mandate of the Department. The Department agrees that the Plan's offer and this Settlement Agreement are not, and shall not be construed as, any sort of admission by Plan of a violation of, or non-compliance with, Section 1389.3 of the California Health and Safety Code, any other provision of the Knox-Keene Act, or any other federal or state statute, law or regulation, or under common law.

L. **Good Faith**. The parties understand and agree that this Settlement Agreement represents their good faith efforts to resolve difficult issues.

M. **Effective Date**. This Settlement Agreement shall be effective on June 11, 2008. The parties have voluntarily executed this Settlement Agreement on the dates shown below:

On Behalf of
The Department of Managed Health Care

Amy Dobberteen
Assistant Deputy Director
Office of Enforcement

Date: June 11, 2008

On Behalf of
PacifiCare of California

Nancy Monk
Sr. Vice President,
Regulatory and Government Affairs

Date: _____

M. **Effective Date**. This Settlement Agreement shall be effective on June 11, 2008. The parties have voluntarily executed this Settlement Agreement on the dates shown below:

On Behalf of
The Department of Managed Health Care

Amy Dobberteen
Assistant Deputy Director
Office of Enforcement

Date: _____

On Behalf of
PacifiCare of California

Nancy Monk
Sr. Vice President,
Regulatory and Government Affairs

Date: 6/11/08

Confidential Attachment A
Specified Former Enrollees

1.
2.
3.

EXHIBIT B

UNDERWRITING/RESCISSION ISSUES TO BE ADDRESSED IN THE PLAN'S CORRECTIVE ACTION PROPOSAL

1) **The Plan's enrollment materials should promote the Plan's processes to complete medical underwriting.**

   At a minimum the Plan should consider whether its Health Care Questionnaire/Application form:

   - Is clear, unambiguous and understandable to the average consumer
   - Is designed to solicit accurate health history information
   - Includes reasonable time periods

2) **The Plan's pre-enrollment health history investigation processes should support the Plan's processes to complete medical underwriting.**

   At a minimum, the Plan should consider whether its operational processes ensure:

   - The review of known and available sources of health information reasonably necessary to develop a comprehensive understanding of the applicant's health history prior to issuing insurance coverage that takes into consideration the applicant's age, clarity of the responses and disclosed medical conditions.

   - That the applicant's responses on the application are accurate and complete taking into consideration language barriers.

   - Thresholds are established to indicate when follow-up inquiry is appropriate and when attestation from brokers, agents and the applicant is necessary.

3) **The Plan's rescission/post-claims investigation practices are initiated promptly and completed in a fair and timely manner that includes notice to the applicant of the investigation and an opportunity to respond.**

   At a minimum, the Plan should consider whether its operational processes ensure:

   - That the enrollee is provided timely notice of the Plan's investigation, the information/issue under review and why the Plan considers this information to be an omission or misstatement.

   - That prior to rescinding the individual policy, the rescission determination is reviewed by staff that is separate from those involved in the initial underwriting.

   - Physician consultations are available during the investigation and appeal process.

- The grievance and appeal process is impartial.

- That the Plan does not employ any compensation or bonus programs in connection with the Plan's rescission processes.

4) **The plan implements a self-audit program to ensure adherence to medical underwriting guidelines, policies and procedures, investigations and rescission procedures.**

The Plan should consider whether its operational processes ensure:

- That timely follow-up and re-training is instituted to correct problems identified from audits.

- The provision of periodic training of all underwriting staff regarding changes to policies and procedures.

After consultation with the Department, Plan may modify the corrective action proposal and the corrective action plan ultimately approved by the Department as necessary to conform with any newly enacted legislation amending section 1389.3 of the Health and Safety Code, promulgation of regulations and/or guidance clarifying pre-enrollment and post-enrollment standards and processes, or judicial opinion affecting section 1389.3 and its interpretation.

EXHIBIT C

ARBITRATION SUBMISSION AGREEMENTS

ARBITRATION SUBMISSION AGREEMENT

Pursuant to Option 2 Set Forth in the Settlement Agreement Between The Department of Managed Health Care and PacifiCare of California

1. Parties. This arbitration submission agreement (the "Submission Agreement") is entered into this ___ day of _____ , 2008 by and between PacifiCare of California ("Plan") and _____ ("Claimant") (Plan and Claimant referred to collectively as "Parties") with reference to the following facts.

2. Nature of Claims Submitted to Arbitration. The Parties recognize that Claimant alleges damages in connection with the prior cancellation by Plan of Claimant's membership agreement in Plan's Individual and Family Plan HMO ("IFP HMO") health care coverage. Under the terms of an agreement between the California Department of Managed Health Care ("DMHC") and Plan executed on or about June 11, 2008 ("Settlement Agreement"), Claimant is eligible to submit his or her claim for resolution by binding arbitration as set forth in this Submission Agreement.

3. Other Legal Remedies Waived. The Parties understand that, with respect to the matters described herein, they both waive all other legal remedies by entering into this Submission Agreement.

4. Dispute Subject to Arbitration. Except any claims that have otherwise been the subjects of an arbitration award or decision, court judgment, settlement, or release of liability, the Parties enter this Submission Agreement for binding and final resolution of any and all claims of Claimant only for damages of any and all types in connection with the Plan's previous cancellation of Claimant's IFP HMO coverage including, but not limited to, reimbursement of Paid Out-of-Pocket Medical Expenses (as defined in Paragraph II.F.2 of the Settlement Agreement) ("Paid Out-of-Pocket Medical Expenses") for medical services rendered during the canceled coverage period that are less than or equal to $25,000.00 in aggregate total.

5. Expedited Proceeding (Total Claim Less Than $25,000.00). Because Claimant's claims are limited to Paid Out-of-Pocket Medical Expenses for medical services rendered during the canceled coverage period that are less than or equal to $25,000.00 in aggregate total, the Parties agree to submit the matter to an expedited proceeding that shall be conducted by a JAMS arbitrator on the basis of a written record without appearance by any party.

6. The Record for the Expedited Proceeding. The record shall consist of evidence of Claimant's Paid Out-of-Pocket Medical Expenses during the canceled coverage period, evidence that such expenses were for medically necessary covered services within the parameters of the benefits structure contained in the Claimant's canceled IFP HMO membership agreement that were not paid or reimbursed by a third party payer, and the Plan's health application, underwriting, cancellation investigation and cancellation determination files that were available at the time of the Plan's cancellation determination and evidence concerning premiums payable

by Claimant for the canceled coverage period. Upon request of the arbitrator, the Parties shall have the right to submit a written statement as well as additional materials.

7. No Discovery Permitted. No discovery shall be permitted, except that Plan may obtain Claimants' medical records and bills for submittal to the arbitrator for purposes of verifying claims, and Claimant must execute written authorizations for the release of medical and other records as reasonably requested by the Plan.

8. Plan Pays Costs for the Arbitrator. Plan will pay for the cost of the arbitrator.

9. Remedies Available In This Arbitration. The available remedies for any arbitration award issued under this Submission Agreement shall be limited to documented Paid Out-of-Pocket Medical Expenses during the period between the effective date of the Plan's previous cancellation of the IFP HMO membership agreement issued to Claimant and the date the Plan offered prospective IFP HMO coverage to Claimant pursuant to the Settlement Agreement, but limited to a total of not more than $25,000.00 in total damages or applicable premium offset rights as set forth below. By agreeing to arbitration under this Submission Agreement, Claimant and Plan hereby relinquish, except as set forth in this Submission Agreement, any and all claims, demands or causes of action arising from or in connection with Plan's cancellation of Claimant's IFP HMO membership agreement. If a decision is made that any medical expenses for the canceled coverage period must be paid or reimbursed and if the arbitrator also finds that Plan is entitled to back premiums, the arbitrator shall offset the amount of back premiums found payable to the Plan from the amounts awarded to Claimant. The Plan and the Claimant shall each bear their own respective attorneys fees and expenses except as otherwise set forth herein.

10. Selection of Arbitrator. The arbitrator shall be selected randomly by JAMS from a group of no more than six arbitrators who are mutually agreed upon by the Department of Managed Health Care and Plan. Such arbitrators shall periodically consult with each other to assure consistency in decision-making.

11. Arbitrator to Apply California Law. The arbitrator shall follow applicable California law, including the Knox-Keene Act and *Hailey v. California Physicians' Service* (2007) 158 Cal. App. 4th 452; 69 Cal. Rptr. 3d 789, (as may be modified by subsequent decisions).

12. Arbitration Decision is Final. Arbitration decisions shall be final, subject to judicial enforcement and appeal in accordance with California Code of Civil Procedure Sections 1285 et seq., and shall resolve all claims and disputes between Claimant and Plan relating to Plan's cancellation of Claimant's IFP HMO membership agreement.

13. Confidentiality. All documents (and copies thereof) exchanged shall be treated as confidential and returned to the producing Parties promptly after conclusion of the arbitration.

14. Claims and Defenses Preserved. All of Plan's claims and defenses are preserved and may be raised in the arbitration under this Submission Agreement including, but not limited to, those based on statute of limitations, or that the cancellation of coverage was appropriate.

15. Limitations Period Not Tolled. No part of the time period between the effective date of the Plan's cancellation of Claimant's IFP HMO membership agreement and the date Claimant requests or selects to participate in the arbitration proceedings shall be excluded from the legal determination concerning the applicability of statute of limitations defenses.

16. No Claims Revived. Neither the making of this Submission Agreement, nor any action of the Plan or the Department of Managed Health Care in connection with the Plan's previous cancellation of Claimant's IFP HMO membership agreement, shall be construed in any way to revive any claim or cause of action of Claimant that expired prior to the date that the Claimant requested or selected to participate in arbitration.

17. Independent Knowledge. The Parties each represent and warrant that in executing this Submission Agreement each has the right and opportunity to secure legal advice from separate and independent legal counsel. Each Party further represents and acknowledges that each of them has entered into this Submission Agreement voluntarily and that the terms of this Submission Agreement and its consequences have been completely read and understood by each Party.

18. Integration. The Parties each acknowledge that this Submission Agreement contains the entire agreement between them with respect to all matters and issues concerning the resolution of the disputes and controversies described herein. In executing this Submission Agreement, neither Party has relied on any inducements, promises, or representations except as expressly contained in this Submission Agreement.

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OPTION 2, Cont'd

19. Arbitration is Final and Binding. The Arbitration decision shall be final, subject to judicial enforcement in accordance with California Code of Civil Procedure Sections 1285 et seq., and shall resolve all claims and disputes between Claimant and the Plan relating to the Plan's cancellation of Claimant's IFP HMO membership agreement. The proceedings (including, without limitation, statements, deliberations, decisions, and documents made, created or issued therein by the arbitrator, any party or any other person) are a compromise of claims and: (i) shall be inadmissible in any other legal or administrative proceeding, and (ii) shall not be used for any purpose in any legal or administrative proceeding, including (without limitation) for purposes of collateral estoppel or res judicata. However, notwithstanding the foregoing, the proceeding may be used to establish that Claimant submitted claims, whether those claims were resolved, and whether the Claimant released any claims. All documents (and copies thereof) exchanged shall be treated as confidential and returned to the producing parties promptly after conclusion of the arbitration.

CLAIMANT

By:_____ Date:_____

_____
[Print Name]

PACIFICARE OF CALIFORNIA

By:_____ Date:_____

_____
[Print Name and Title]

ARBITRATION SUBMISSION AGREEMENT

Pursuant to Option 3 Set Forth in the Settlement Agreement Between The Department of Managed Health Care and PacifiCare of California

1. Parties. This arbitration submission agreement (the "Submission Agreement") is entered into this ___ day of _____ , 2008 by and between PacifiCare of California ("Plan") and _____ ("Claimant")(Plan and Claimant referred to collectively as "Parties") with reference to the following facts.

2. Nature of Claims Submitted to Arbitration. The Parties recognize that Claimant alleges damages in connection with the prior cancellation by Plan of Claimant's membership agreement in Plan's Individual and Family Plan HMO ("IFP HMO") health care coverage. Under the terms of an agreement between the California Department of Managed Health Care ("DMHC") and Plan executed on or about June 11, 2008 ("Settlement Agreement"), Claimant is eligible to submit his or her claim for resolution by binding arbitration as set forth in this Submission Agreement.

3. Other Legal Remedies Waived. The Parties understand that, with respect to the matters described herein, they both waive all other legal remedies by entering into this Submission Agreement.

4. Dispute Subject to Arbitration. Except any claims that have otherwise been the subjects of an arbitration award or decision, court judgment, settlement, or release of liability, the Parties enter this Submission Agreement for binding and final resolution of any and all claims of Claimant only for damages of any and all types in connection with the Plan's previous cancellation of Claimant's IFP HMO coverage including, but not limited to, reimbursement of Paid Out-of-Pocket Medical Expenses (as defined in Paragraph II.F.2 of the Settlement Agreement) or claims that have been or could be asserted by Claimant in connection with Claimant's membership in the IFP HMO, any benefits or damages due under the IFP HMO, and any damages relating to Plan's cancellation of Claimant's membership in the IFP HMO.

5. Arbitration Proceeding (Total Claim Exceeding $25,000.00 or Including Claims for Damages Other Than Paid Out-of-Pocket Medical Expenses for Medical Services Rendered During Canceled Coverage Period). The Parties agree to submit the matter to binding arbitration held in Sacramento, San Francisco, Los Angeles, or San Diego (whichever is more convenient to the Claimant) before one arbitrator.

6. Arbitration To Be Administered By JAMS. The arbitration under this Submission Agreement shall be administered by JAMS.

7. Applicable Rules. The arbitration shall be administered pursuant to JAMS's Comprehensive Arbitration Rules and Procedures, subject to the modifications set forth in this Submission Agreement.

8. Plan Pays Costs for the Arbitrator. Plan will pay for the cost of the arbitrator.

9. Remedies Available In This Arbitration. By agreeing to arbitration under this Submission Agreement, Claimant and Plan hereby relinquish, except as set forth in this Submission Agreement, any and all claims, demands or causes of action arising from or in connection with Plan's cancellation of Claimant's IFP HMO membership agreement. If a decision is made that any medical expenses for the canceled coverage period must be paid or reimbursed, and if the arbitrator also finds that Plan is entitled to back premiums, the arbitrator shall offset the amount of back premiums found payable to the Plan from the amounts awarded to Claimant. The Plan and Claimant shall each bear their own respective attorneys fees and expenses except as otherwise set forth herein.

10. Selection of Arbitrator. The arbitrator shall be selected randomly by JAMS from a group of no more than six arbitrators who are mutually agreed upon by the Department of Managed Health Care and Plan. Such arbitrators shall periodically consult with each other to assure consistency in decision-making.

11. Arbitrator to Apply California Law. The arbitrator shall follow applicable California law, including the Knox-Keene Act and *Hailey v. California Physicians' Service* (2007) 158 Cal. App. 4th 452; 69 Cal. Rptr. 3d 789, (as may be modified by subsequent decisions).

12. Arbitration Decision is Final. Arbitration decisions shall be final, subject to judicial enforcement and appeal in accordance with California Code of Civil Procedure Sections 1285 et seq., and shall resolve all claims and disputes between Claimant and Plan relating to Plan's cancellation of Claimant's IFP HMO membership agreement.

13. Confidentiality. All documents (and copies thereof) exchanged shall be treated as confidential and returned to the producing Parties promptly after conclusion of the arbitration.

14. Claims and Defenses Preserved. All of Plan's claims and defenses are preserved and may be raised in the arbitration under this Submission Agreement including, but not limited to, those based on statute of limitations, or that the cancellation of coverage was appropriate.

15. Limitations Period Not Tolled. No part of the time period between the effective date of the Plan's cancellation of Claimant and the date Claimant requests or selects to participate in the arbitration proceedings shall be excluded from the legal determination concerning the applicability of statute of limitations defenses.

16. No Claims Revived. Neither the making of this Submission Agreement, nor any action of the Plan or the DMHC in connection with the Plan's previous cancellation of IFP HMO membership agreements, shall be construed in any way to revive any claim or cause of action of Claimant that expired prior to the date that the Claimant requested or selected to participate in arbitration.

17. Independent Knowledge. The Parties each represent and warrant that in executing this Submission Agreement each has relied on legal advice from separate and independent legal counsel. Each Party further represents and acknowledges that each of them has entered into this Submission Agreement voluntarily and that the terms of this Submission Agreement and its consequences have been completely read and understood by each Party.

18. Integration. The Parties each acknowledge that this Submission Agreement contains the entire agreement between them with respect to all matters and issues concerning the resolution of the disputes and controversies described herein. In executing this Submission Agreement, neither Party has relied on any inducements, promises, nor representations except as expressly contained in this Submission Agreement.

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19. Arbitration is Final and Binding. The Arbitration decision shall be final, subject to judicial enforcement in accordance with California Code of Civil Procedure Sections 1285 et seq., and shall resolve all claims and disputes between Claimant and the Plan relating to the Plan's cancellation of Claimant's IFP HMO membership agreement. The proceedings (including, without limitation, statements, deliberations, decisions, and documents made, created or issued therein by the arbitrator, any party or any other person) are a compromise of claims and: (i) shall be inadmissible in any other legal or administrative proceeding, and (ii) shall not be used for any purpose in any legal or administrative proceeding, including (without limitation) for purposes of collateral estoppel or res judicata. However, notwithstanding the foregoing, the proceeding may be used to establish that Claimant submitted claims, whether those claims were resolved, and whether the Claimant released any claims. All documents (and copies thereof) exchanged shall be treated as confidential and returned to the producing parties promptly after conclusion of the arbitration. In the event that a settlement or award agreed to or issued is based upon bills received by a Claimant from a provider prior to June 11, 2008 that remain owed but were not paid by a Claimant to a provider, Plan shall, at its sole discretion, have the right to directly resolve any such bills with the billing provider and deduct the amount paid to the billing provider from the amount of the settlement or award. If the Plan chooses to pay any such providers directly, it shall do so within 45 days of the date of receipt of the final arbitration award or decision.

CLAIMANT

By:_____ Date:_____

_____
[Print Name]

PACIFICARE OF CALIFORNIA

By:_____ Date:_____

_____
[Print Name and Title]